Health Information Portability and Accountability Act of 1996: An Analysis of its Implication Using an Adapted Model

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Abstract

The HIPA Act of 1996 is analyzed using an adapted model: Approach, Need, Assessment, and Logistics. The adaptation comes from McInnis-Dittrich (1994). McInnis-Dittrich uses the word ANALYSIS as a model structure to analyze proposed/enacted policies or programs. The structure was modified to better fit general policies and to flow from element to element by only utilizing the first three components of the structure and by adding a new element, Logistics, which facilitates an outcome and implementation analysis. In addition, the model has been enriched with assessment of values and consequences (intended and unintended). As illustrated through this paper, the adapted model seems to fit well with analyzing the HIPA Act of 1996, a macro level policy.

Introduction

There are many policy models that can be used to analyze proposed and enacted policies. However, most of these focus on the purpose of the policy, and they are more descriptive. Rare are broad policy structure models that can be applied to any policy (micro, mezzo, macro) for an overall analysis, to include descriptive and evaluative components. The attempt in this paper is to test an adapted micro level model on a macro level policy.

A twofold approach is used to illustrate and test the modified model. First, the structure of the adapted model is presented and discussed. Second, the new model structure is applied to the Health Information Portability and Accountability Act of 1996 (HIPA Act of 1996; PL. 104-191). This analysis of the HIPA Act of 1996 primarily focuses on Title II—Preventing Health Care Fraud and Abuse; Administrative Simplification; Medical Liability Reform. This Act is analyzed using an adaptation of McInnis-Dittrich's (1994) model for policy analysis. McInnis-Dittrich uses the letters of *ANALYSIS* for the eight elements of the model: *A* is *Approach* used to the policy*; N* is the *Need* the policy is addressing*; A* is *Assessment* of strengths and weaknesses of the policy; *L* is the *Logic* within the policy; *Y* is *Your Reaction,* which refers to the professional's response to the policy; *S* is the financial *Support* for the program or policy*; I* is *Innovation* to change the policy or program if necessary*;* and *S* is *Social Justice* assessing to what degree is the policy addressing societal and social work values of social justice.

The elements utilized from McInnis-Dittrich's (1994) model are *Approach*, *Need*, and *Assessment*. This author has added a fourth element to the model, *Logistics*—the effects of implementing the policy and its implications (cost, efficiency, adequacy, and goal attainment*).* In addition to strengths and weaknesses, which is part of the *Assessment* element of the original model, values and intended and unintended consequences are also assessed. The values component was adapted from Prigmore and Atherton's (1986) and Chamber and Wedel's (2009) model; the stakeholder component imbedded in the values section was adapted from Flynn's (1992) and Moroney's (1981) models (see appendix A for more details of model structure). A demonstration of the adapted model is given by analyzing the HIPA Act of 1996. That is, the modified model is tested to determine how well it fits with a macro level policy.

McInnis-Dittrich's (1994) model was chosen because it was designed to analyze the effect that proposed and enacted policies might have in an agency. The focus of the model is to determine if the proposed or enacted policy addresses the targeted need effectively, which includes a professional response to the policy. Simmons and Wright (2008) used this policy model to compare national practices of mental health in the US and the UK. Their analysis seemed adequate for structure. However, the adapted model was strengthened by eliminating *Your Reaction*, *Support*, *Innovation*, *Logic*, and *Social Justice* components and streamlining *Approach, Need, Assessment,* and *Logistics*. Modifications were made to facilitate dynamic fluidity and to allow analysis beyond micro to macro policy levels.

The model has been changed to be interactive between elements—recognizing and discovering how the elements influence one another facilitates greater scrutiny and deeper insight into the intent and the consequence of a policy. Thus, components were removed (*Your Reaction, Innovation, Support, Social Justice, and Logic*) because they were inadequate to guide the analyst into such discernment and understanding of a policy. Furthermore, the model was adjusted to allow the analyst to evaluate policies without restriction on the type or level of policy. For example, McInnis-Dittrich's (1994) component of *Your Reaction* asks for the analyst's reaction. The analyst's goal is not to be reactive but objective and critical—the analyst's emotions and values might interfere with the analysis and inadvertently superimpose his/her values rather than the values within the policy. Although it is understood that one cannot remove oneself completely, minimizing self-imposed values and maintaining a neutral stance to effectively analyzing a policy is necessary. *Support* was excluded because it had limitations in assessing outcome in that *Support* only looks at the finances of the policy. Cost, efficiency, adequacy, and goal attainment are necessary factors in outcome analysis. *Innovation* was not conceptually removed from the adapted model; rather, it was redefined within the *Assessment* and *Logistics* components. *Logic* was not included because each component presumes to follow a logical order. For example, as *Approach* and *Need* of the policy are assessed, the analyst can determine the logic of the policy within each element. Finally, *Social Justice* was the only value examined in McInnis-Dittrich's (1994) model. This limited the assessment of values. Thus, the values section within the *Assessment* component was expanded not to just include social justice but other values as well.

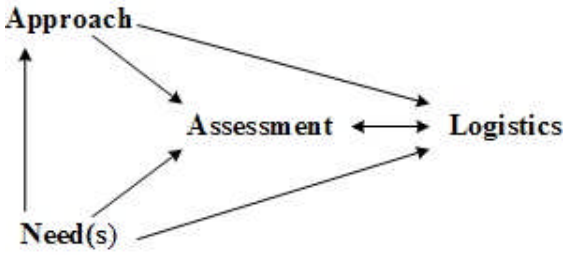
HIPA ACT of 1996

The stated purpose of the HIPA Act of 1996 is "to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets…" (PL 104-191, p.1). This purpose changes the policies of insurance companies, providers, and how individuals receive medical care. Furthermore, it goes on to state, "to combat waste, fraud, and abuse in health insurance and health care delivery…" (PL 104-191, p.1). The prevention of waste, fraud, and abuse in health insurance and health care delivery is the primary area of analysis. This prevention component influences dynamics in practice and research (Arnold, 2008; Fisher, 2008; Fisher & Oransky, 2008; Greenberg, Ridgely, & Hillestad, 2009; Lawrence, 2007).The protection of consumer/patient information, for example, limits researchers' recruiting process. Nevertheless, the overarching goal of the policy is prevention and protection.

Understanding this Act is critical for two reasons. First, the consequences of violating this Act carry penal code sentences. However, it has been debated how and whether prosecution will be enforced (Wielawski, 2009). Second, the Act's aim at prevention and protection is to help the consumer receive high quality service delivery and information regarding services provided to the consumer to be protected (McDonald, 2009; Moore, Snyder, et al. 2007; Walfish & Ducey, 2007). Prevention and protection are present at the macro, mezzo, and micro level of this policy. At the macro level, the policy attempts to prevent fraud and abuse of government and consumer resources (Bodenheimer & Grumbach, 2002). According to Bodenheimer and Grumbach (2002), in the 1990s, managed care was about capitation. Bodenheimer and Grumbach state, "…capitation was expected to slow rising costs, reduce unnecessary medical services, and correct the imbalance between specialty and primary care" (p. 44; Karger & Stoesz, 2002). At the mezzo level, the policy aims to prevent information pertaining to services delivered to become public domain. At the micro level, the policy focuses on basic privacy protection which aligns with statements Ginsberg and Miller-Cribbs (2005) made regarding professional responsibility (Gilbert & Terrel, 2005; Karger & Stoesz, 2002; Lightfoot, 2003). According to Ginsberg and Miller-Cribbs "Human services professionals should think and act beyond their daily tasks to the larger concepts of social change and human services delivery planning" (p. 207). Thus, the provider's task is to protect patient information at all levels.

Policy Analytic Framework

The next section of this paper uses the modified model to analyze the HIPA Act of 1996. Below is a diagram to place the model in perspective (see Figure 1 for model outline):



1. **Approach**—How the policy is organized and methods used
2. **Need**—The needs the policy attempts to address
3. **Assessment**—what is at stake (feasibility; quality; effectiveness)? Is the policy meeting the need? Are their conflicts in values? How likely will there be for misinterpretations and misapplications?
   Values (efficiency, adequacy, and equity)
   - Stakeholder Values at micro, mezzo, and macro level (first identify who the stakeholders are before and after the policy was enacted) (fraternity, equality, liberty)
   - Social Work Values

   Strengths
   Weaknesses
   Intended Consequences
   Unintended Consequences
4. **Logistics**—the effects of implementing the policy and its implications (cost, efficiency, adequacy and goal attainment)

Figure 1. ANAL Policy Model[1]

[1] The model was adapted from: McInnis-Dittrich (1994)—Approach, Need, Assessment; Prigmore and Atherton (1986), Chamber and Wedel (2009), Flynn (1992) , Moroney (1981)—Values; and Jose Carbajal—Logistics.

As shown in the diagram above, the elements are dynamic and intertwined. First, *Approach*, which looks at the structure of the policy, is influenced by *Need*(s). Second, *Approach* and *Need(s)* influence *Assessment*. *Assessment* in essence is the core of analyzing the policy. Third, *Assessment* is influenced by *Approach*, *Need(s)*, and *Logistics*. Finally, *Logistics* is influenced by *Approach*, *Needs*, and *Assessment*. Note that this model is used with an active policy. However, to analyze a proposed policy, the sequence of analyzing the policy would be *Need(s)*, *Approach*, *Assessment*, and *Logistics*. The sequence changes because the need, which is identified and determined first, will influence the approach to the policy. Therefore, for a proposed policy, the arrow changes direction.

Analysis of HIPA Act Using the Adapted Model

Approach

In this section, the policy is analyzed regarding organization. The HIPA Act has four titles. Title I is Health Care Access, Portability, and Renewability. Under Title I, the main issues addressed are: 1) access and portability for those with pre-existing conditions; 2) regulation regarding the protection of patient health information; and 3) the availability of health care insurance. Title II, the section of policy under analysis, deals with Preventing Health Care Fraud and Abuse; Administrative Simplification (electronic exchange standards and security of health care information); and Medical Liability Reform. Additionally, Title II provides regulations establishing, monitoring, and reporting standards for fraud and abuse of health care services. Furthermore, sanctions and penalties are established for fraud and abuse of health care services. Finally, the national healthcare clearinghouse was established. Title III is the Tax-Related Health Provisions. Under Title III, higher tax deduction provisions are made to self-employed individuals; deduction for medical savings account is allowed; regulation regarding long-term health care services and contracts and state insurance pools receive exemptions from income tax. Title IV is Application and Enforcement of Group Health Plan Requirements. This Title addresses group health care plan requirements and continuation of care coverage. Finally, Title V is Revenue Offsets. Under Title V, company owned life insurance is regulated; regulation on individuals who lose US citizenship and tax compliance reports on those living abroad is established.

Need

In this section, the policy is analyzed on the needs the policy attempts to address. The need the policy addresses, as stated above, is “to combat waste, fraud, and abuse in health insurance and health care delivery…” (PL 104-191). The need to control fraud and abuse is met by establishing federal, state, and local law enforcement. Furthermore, current sanctions are revised for fraud and abuse, and a national data collection is established to report final adverse actions against practitioners and suppliers. The sanctions include civil monetary and imprisonment penalties for various violations in which criminal law is revised to protect confidential information disclosed in court proceedings that are not part of the investigation. The revised sanctions are intended for those that are fraudulent and that abuse the health care system via “fraud, theft, embezzlement [coding or unnecessary medical claims on item or service in order to receive greater payment], breach of fiduciary responsibility, or other financial misconduct” (PL 104-191).

Finally, the need to combat waste is achieved through the establishment of national electronic transmission which establishes uniformity and reduces duplication and coordination of Medicare related plans. The duplication and coordination of Medicare related plans is to facilitate exchange of information amongst practitioners and suppliers. Furthermore, under this section, disclosure of protected information for coordination of services is permitted without patient authorization. The consent of the consumer is optional for these purposes except the disclosure of psychotherapy notes. Thus, waste is reduced through this process of streamlining information, communication, and coordination of services.

Assessment

Values. Values are ingrained in social welfare policies (Moroney, 1981). These values often compete or are dimensionally juxtaposed. According to Moroney (1981):

> Values influence the selection of a specific policy issue and how it will be defined. Values are the basis for setting policy goals and objectives, for selecting criteria, for comparing policy options to achieve these goals and objectives, and for evaluating policies once they are implemented. (p. 85)

Furthermore, values are often more subtle than obvious. Therefore, scrutiny is required to unmask hidden values that sometimes mask purposes. The HIPA Act does not escape this reality. The traditional value perspectives of *efficiency*, *adequacy*, and *equity* by economists are helpful here (Chambers & Wedel, 2009; Moroney, 1981). *Efficiency*, which has to do with cost-effectiveness, is used in this policy. One of the purposes of the policy is to reduce health care cost.

The question of whether this is accomplished is answered by *adequacy*, which has to do with the magnitude of the policy to create sufficient changes. In this policy, in terms of cost reduction as an overall goal, adequacy is not accomplished (Banks, 2006; Bodenheimer & Grumbach, 2002). However, in terms of fraud and abuse, the policy is effective in capturing those already prosecuted. Furthermore, the coordination of services among providers and health care clearinghouses meet the goal of cost reduction. The establishment of uniformity code sets for treatment and billing seems to reduce cost as well.

Equity, which has to do with fairness and equalization of service provision, seems to be prominent in this policy. *Equity* is most prevalent in Title I and throughout the rest of the Titles. Specifically, on Title I, the portability and access of health care regulates insurance policies for individual and group markets to help the consumer. *Equity* is also seen through the other Titles via cost reduction, fraud and abuse of health care services. Therefore, the prevention of fraud and abuse, specifically in Title II, is to decrease the overall expenditure for public health care services.

Stakeholder values. Within this policy, the stakeholders are insurance companies, healthcare providers, consumers, and the federal, state, and local government. Each individual entity has its values. The insurance companies focus on profit and delivery of services at a high profit margin with low cost to providing those services. The provider's focus is two-fold. First, the provider focuses on providing services. Second, which is most important from a billing perspective, is reimbursement for services provided. The consumer's perspective is the quality of services provided and efficiency. In addition to efficiency, the underlined value is equity and liberty, and to have services available and to choose from whomever the consumer decides. The

federal, state, and local government focuses in reduction of cost (*efficiency*) to the government in all the levels, and to prevent fraud and abuse (*adequacy*). In terms of equity, the government regulates how these services should be provided. The establishment of national data code sets provides equity for all regardless of gender or race. Therefore, "based on the recognition of common human needs," the government has placed (within this policy) a residual approach to repair a health care system that is broken and in need of assistance in which universal provisions for services and prevention of health care fraud and abuse are established (Moroney, 1981, p.94).

Insurance companies. As the government established universal regulation on health care services, insurance companies ensured that the profit margin would remain high. According to Bodenheimer and Grumbach (2002), "…the force that began to erode professionalism dominance was not the government but the large private managed care corporations that forcefully asserted their influence in the 1990s" (p.65). This was done by creating health maintenance organizations (HMOs) and preferred provider organizations (PPOs) best known as In-Network providers. The implication was that although a greater freedom of services is supposed to exist in health care, it does not due to HMOs and the creation of Network providers. In other words, individuals are discouraged to seek out-of-network providers due to higher out-of-pocket expenses. In effect, the insurance companies use the same approach of efficiency the government uses in uniform fee schedules to reduce cost (Gilbert & Terrell, 2005); consequently, insurance companies use selective contracting (network providers) as a mechanism to reduce costs (Brodenheimer & Grumbach, 2002)

Providers. For providers, efficiency through the national clearinghouse was achieved. However, equity was decreased. In order for providers to provide services, they have to be paneled by insurance companies; otherwise, the consumer would have to pay privately or pay higher fees for the services that someone else who is contracted with an insurance company could provide and thus pay less for the services. Also, this means that providers are more willing to provide services to those that are privately funded rather than through HMOs or Managed Care companies. Thus, not everyone has access to all the providers but only to selected providers within the medical plan. Furthermore, providers are limited to whom they are able to provide services because consumers are less likely to seek out providers who are not within their network.

Consumer. The policy is supposed to provide liberty to the individual to choose among health care providers or services. However, it limits freedom based on HMOs and participating providers within the medical plan of the person. The question of equity is also addressed through providing services to everyone. However, as stated above, consumers do not have a choice based on their plan. Thus, equity of services for consumers is limited to within network providers.

The federal, state, and local government. Fraud and abuse of the health care system has been prevalent. Therefore, the residual model of Moroney's (1981) second step as discussed above is applied here (Moroney, 1981, p.92). The second area is the incremental social change (Moroney, 1981). The radical reform is seen through sanctions and penalties of those that violate the policy (Moroney, 1981, p. 93).

Social work values. The values ingrained in the profession of social work are addressed in this policy. Specifically, the values addressed are *service, social justice, dignity and worth of the person, integrity,* and *competence*. Some of the values are more direct, whereas others are indirect.

Service. The manner in which *Service* is addressed is by the purpose of the policy: to reduce cost and prevent fraud and abuse in healthcare.

Social justice. As stated above, one of the government's values within this policy is fraternity. Fraternity is seen through the equity of service provision. However, due to the nature of stakeholder's responses to the policy implementation, this might not be accomplished as desired.

Dignity and worth of the person. The privacy rule seeks to protect the dignity of the person by ensuring patient health information is protected from misuse or inappropriate disclosure (Gostin & Nass, 2010).

Integrity. The value of integrity is throughout this policy, as a significant purpose is to ensure no fraud and abuse exists among those providing the services (insurance companies and providers). Therefore, the policy overtly demands integrity.

Competence. Although competence is more of an indirect value, the HIPAA Privacy Rule establishes guidelines for providers to ensure consumers are fully aware of their treatment and use of their information. This is accomplished in two ways. First, the consumer must acknowledge that he or she understands the informed consent and office practice policies. Second, the provider is supposed to explain to the consumer the extent of confidentiality and how laws apply to their protected information.

Weaknesses. The weakest aspect of the HIPAA policy might be the use of an information disclosure for billing purposes and information held by noncovered entities. Under this policy, disclosure of patient information is authorized for processing, clearing, settling, billing, transferring, reconciling, or collecting a payment for, or related to, health plan premiums. While the Privacy Rule protects patient health information held by covered entities (insurance companies, providers, and health care clearinghouses), Gostin and Nass (2010) point out, "…personal data held by numerous noncovered [sic] entities remain unregulated, such as data management or data warehousing companies, pharmaceutical companies, and public health agencies" (p. 1373). In addition, though patients can give consent to release their information, many patients do not understand the consent they are giving (Gostin & Nass, 2010).

The use of technology increases the risk of protected information to be breached. Technology might cause an unintended disclosure. For example, electronic documents might be sent to the wrong place or someone might break into the server where the patient protected information is kept (Gostin & Nass, 2010). In the study conducted by Cooper, Collman, and Neidermeier (2008), they explored how breach of confidential information occurs. They discussed the technical glitch Kaiser Internet Patient Portal (Kaiser Permanente Online [KP online]) experienced whereby confidential and member's personal health information was emailed to unintended member queries. This breach, due to server malfunction and not to human error, exposed confidential information to people without authorization to receive such information.

Strengths. The strengths of the policy are based on the attempt to prevent fraud and abuse of the health care system. The national data collection of adverse actions against practitioners and suppliers allows the public to feel safe and protected. The sharing of data with representatives of health plans reduces cost. Furthermore, the access to documentation in respect to fraudulent activities facilitates the monitoring and prosecution process.

The establishment of safe harbors aims at protecting the public. The intent is to increase patient protection and reduce cost. The safe harbors are in place through the access to health care services that provide freedom of choice among health care providers, the ability of health care facilities to provide services in medically underserved areas, the cost to federal health care programs is reduced through monitoring potential over and under-utilization of health care services; and, the ability to contract with health care providers to provide services that are in existence or nonexistence. In addition, practitioners are allowed to waive coinsurance and deductible amounts in order for the patient to continue receiving the service if the practitioner determines the patient is in financial need. However, the practitioner cannot advertise or solicit patients by stating that the practitioner will waive the coinsurance and deductible amounts.

The policy also includes sanctions for violation of healthcare fraud and abuse. This includes "unlawful manufacturing, distribution, prescription, or dispensing of a controlled substance" and false certification of services (PL 104-191). The penalties vary from license revocation, suspension, or termination to life imprisonment. This also includes loss of contract. However, depending on the severity of the violation, practitioners receive an opportunity of a corrective action plan to complete. Nevertheless, once the adverse action is finalized, the practitioner's name and fraudulent act is reported to a national data bank.

The consumer is also protected in the process of prosecuting a provider for fraud and abuse. Thus, obstruction of criminal investigations of health care offenses is a provision to protect the public. In this provision, there is a limitation clause that states:

> Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health. (PL 104-191, sec. 248.3486.4[e])

This provision clause protects the consumer from information disclosed to the practitioner in confidence.

In addition, the Privacy Rule in section 261 to 264 was modified by the Department of Human Health Services (DHHS) in 2002 to strengthen this clause even further (65 FR 82462). DHHS increased security measures for protecting individual's information and gave significant rights to consumers such as the use and disclosure of their information. Thus, the privacy section becomes the strongest section of the HIPA Act.

Finally, the strongest aspect in terms of reducing cost to health care is through the establishment of health care clearinghouses. The administrative cost reduction is to all the stakeholders through the electronic exchange of information. The electronic exchange includes health claim attachments, plan enrollment and disenrollment, eligibility for a health plan, health care payment and remittance advice, health plan premium payments, first report of injury, health claim status, and referral certification and authorization. The electronic exchange process also accommodates the needs of specific providers. The establishment of code sets to uniquely identify a person and treatment diagnostic allows for standardized allowable payments for specific codes. The unique identifiable code is for both patient and provider or supplier. The patient has the identification number on their medical card and the provider or supplier has the national provider identifier (NPI) number.

Intended consequences. Intended purposes of the policy are more obvious and overt. For example, the establishment of uniformity for treatment and payment shows how the purpose of the policy is meeting this goal. Moreover, the electronic exchange of information to electronically standardized documents is to reduce cost and medical errors (K. Chung, D. Chung, & Joo, 2006). Consequently, however, a great increase in technology use and creation of new markets was expanded (K. Chung, D. Chung, & Joo, 2006). Furthermore, the Privacy Rule is geared to protect the privacy of individual Patient Health Information (PHI) (Committee on Child Abuse and Neglect, 2010; Ness, 2010). In accordance to the purpose of the policy, the Privacy Rule was modified in 2002 by DHHS to ensure that consumers are protected, especially with the use of electronic transactions.

Unintended consequences. In policy, interpretation is not consistent. Therefore, unintended consequences result from the policy. For example, for billing purposes, providers are supposed to use the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT) codes. In addition, the policy states that only medically necessary treatments are reimbursable (section 231e). The problem lies in the misuse or over use of diagnostic codes for reimbursement purposes. Codes such as V61.20 (Parent-Child Relational Problem) or V61.10 (Partner Relational Problem) are not reimbursable because they are not considered medically necessary. Therefore, providers use codes such as 309.3 (Adjustment disorder with disturbance of conduct) or 309.28 (Adjustment disorder with mixed anxiety and depressed mood). The overuse or misuse of these codes is fraud and abuse, to an extent, according to the policy. However, to prosecute someone for misusing a diagnostic code is more difficult and costly. According to section 231e of the HIPA Act, a person is not supposed to use code sets in order to receive "greater payments." Consumers often seek services for issues not considered medically necessary. Under the HIPA Act, only medically necessary services are reimbursed; thus, the HIPA Act is violated.

The creation of multiple Electronic Data Interchanges (EDI) and the increase of formats that sometimes do not meet specific entity requirements has been a challenge (K. Chung, D. Chung, & Joo, 2006). This has also required providers to increase maintenance of technological software to ensure security, which was purposefully designed to protect consumer's information. In addition, this has increased cost to stakeholders to keep up with developing technologies and improvements (K. Chung, D. Chung, & Joo, 2006).

Another unforeseen consequence is the effect the policy has had on researchers. In a study conducted by Ness (2010) to determine whether the privacy rule has affected researchers, she found "a majority of respondents reported that the degree to which the rule made research easier was low," and "that the degree to which the rule made research more difficult was high" (p. 2166; Campbell, Sosa, Rabinovici, & Frankel, 2006; Damschroder et al., 2007; Gostin & Nass, 2010). In addition, in terms of randomization for research studies, the Privacy Rule limits the researcher's ability to conduct promising studies in which valid conclusions could be made (Damschroder et al., 2007).

A complete juxtaposed consequence has been the increased risk of inappropriate accessing of PHI (K. Chung, D. Chung, & Joo, 2006). This consequence is due to the easy accessibility of information. For example, agencies usually keep files in a central location that is available to all those that have access. Technically, agencies are supposed to safeguard this information with security measures that decrease the disclosure of information to other staff members of the agency that are not involved in the case. However, it is a common practice in agencies to debrief

about cases. This is not an issue if the PHI is de-identified; in the process of debriefing however, partially due to the nature of the case and Freudian slips, PHI information is disclosed to someone that is not supposed to have access to that information. This also leads to other consequences of electronic use. More is discussed on this in the *Logistics* section.

Logistics

In this section, the policy is analyzed concerning the effects of the implementation of the policy. There is no immediate effect on cost reduction, and uncertainty exists on how much has been saved (Banks, 2006; Bodenheimer & Grumbach, 2002). However, there is agreement on the efficiency created through the electronic transaction, which is expected to reduce cost in the long run. According to Chung, Chung, and Joo (2006), "although the initial startup cost is estimated to be considerable, most agree that long-term savings will be greater" (p. 55). Furthermore, the execution of uniformity for exchange of information has been problematic in terms of the type of software and technology used (K. Chung, D. Chung, & Joo, 2006; Huang, Chu, Lien, Hsiao, & Kao, 2009). Gaps might exist in technology across stakeholders. For example, in order to reduce expenditures, providers might not have access to the most updated software. Therefore, this policy, in terms of efficiency is setup to have long-term savings while increase of cost is upfront (Banks, 2006).

In addition, PHI delays consumers from receiving services. For a seamless process to occur and no interruption of services, it requires providers to be in collaboration or associated to different entities; otherwise, the process of releasing information becomes cumbersome and tedious (Huang et al., 2009). Huang, Chu, Lien, Hsiao, and Kao (2009) suggest using software that will de-identify the patient's information and create pseudonymity. In this way, information could be provided to others without needing authorization from the patient. This seems to help in cases where immediate medical decisions need to be made and in decreasing duplication of services. For example, if a consumer had been receiving services somewhere else for a problem that has already been determined, the same procedure that another provider might have performed due to an initial visit, the procedure might be eliminated and thus reduce cost.

Discussion/Conclusion

The HIPA Act of 1996 is a comprehensive policy. However, this policy is rarely viewed for the total effect it has in society. Most people focus on the PHI section and neglect the national uniformity it has created on health care services. Another policy that is neglected is continued health insurance coverage known as COBRA, which is intended to ensure that consumers do not lose health care benefits in between employments. COBRA was established under the purpose of the HIPA Act of 1996, "to improve portability and continuity of health insurance coverage…" (p. 1). The current policy signed by President Obama, *Patient Protection and Affordable Care Act* (PPACA) appears to be an extension of the HIPA Act of 1996. Therefore, in terms of changes to the health care system, PPACA only appears to make revisions to other policies already in place in addition to eliminating and adding other programs.

In terms of the model, the modifications were beneficial to analyzing this policy. The element *Approach* was redefined as how the policy is organized and the methods used. There were no changes to the *Need* element, which was defined as the need the policy is addressing. The *Assessment* element was redefined as: 1) what is at stake (feasibility, quality, effectiveness)? Is the policy meeting the need, and are their conflicts in values? How likely will there be for misinterpretations and misapplication? 2) Values (efficiency, adequacy, and equity), stakeholder

values at micro, mezzo, and macro level (first identify who the stakeholders are fraternity, equality, and liberty), social work values, strengths and weaknesses (intended and unintended consequences). The *Logistics* element was defined as the effects of implementing the policy and its implications (cost, efficiency, adequacy and goal attainment).

The structure of the modified model is easy to follow. The discussion within each element provides a comprehensive understanding of the policy. Furthermore, the *Logistics* element is helpful in analyzing the implementation and its implications. Often models do not include an evaluative component. Thus, this new model expanded the analysis. This allowed for a breadth and depth evaluation of the policy. Furthermore, as policies have values ingrained, it was necessary to add a value component to the *Assessment.* Additional elements to *Assessment* of feasibility, quality, effectiveness, strengths, and weaknesses provided framework to include the intended and unintended. In McInnis-Dittrich (1994), *Social Justice* is one of the elements to assess values; however, there is only a broad level focus and it does not flow from element to element.

Regarding the discussion within each component, an explanation is needed. Although some of the sections had greater discussion than others and might seem imbalanced, the purpose of policy analysis is to ensure comprehensive scrutiny. One must consider the reality of policies which are inherent to misinterpretations. That is, policies address a need which is carried out with an intended consequence in mind based on a goal. However, once a policy is enacted, it is open to interpretation and thus unintended consequences ensue. Therefore, the discussion should not be weighed on the balance of each section but rather on comprehensiveness. Moreover, the modified model accomplishes the purpose of analyzing a policy at a macro level seamlessly.

A limitation within this policy analysis is the stakeholders' section. A suggestion for improving this area is to look at who influences the policymaker. The pharmaceutical companies, for example, were not included. They play a strong role in policymaking and therefore they must be considered as well. This limitation highlights a reality of policy analysis—stakeholders are within complex systems in which lobbying often obfuscates each individual's role. There are two aspects to consider when analyzing stakeholders: the lobbyists' influence on the policymakers and the population (groups) affected once the policy is enacted. This dual approach of pre and post policy enactment analysis would illuminate who are the stakeholders.

Finally, a limitation of the adapted model is based on the fact that it has only been tested on a macro level policy. In order to determine suitability with other policies it needs to be tested with micro and mezzo policies. It is also encouraged to retest this adapted model with another macro policy to corroborate the validity of its claim.

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